

# Critical Incident Reporting Trend Analysis: 2014



## 2014 Critical Incident Reporting: Trend Analysis

### OVERVIEW

The Division of Developmental Disabilities (DDD) created an online reporting system for Critical Incident Reports (CIR) that was implemented on January 1, 2005. The system allows Community Support Providers (CSPs) to submit required reports electronically and allows the DDD to analyze data. The purpose of developing an online reporting system was to streamline the reporting process for CSPs. Implementation of this system coincides with the first day of the calendar year; therefore, CIR Annual Reports are issued according to the calendar year rather than the fiscal year.

The population covered by the CIR system includes all people receiving services funded through the DDD's CHOICES Waiver<sup>1</sup>, Community Training Services (CTS) and private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (LifeScape). Policy Memorandum 11-02 stated that although the DDD does not have authority to require providers to report allegations of abuse, neglect, exploitation of non-division funded persons, it is best practice and ensures due diligence to report these allegations. Providers have obtained releases of information from these participants and/or their guardians who do not receive Home and Community Based Services (HCBS) or CTS. Providers began submitting these incidents in September 2010.

The ninth annual CIR report that provides a summary review of the data submitted by the nineteen CSPs and one private ICF/IID, aggregated for calendar year 2014. The DDD's intent is to issue a comprehensive trend analysis on an annual basis while providing specific reports to each CSP on a quarterly basis. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative and proactive initiatives. The DDD hopes that these reports will be helpful to administrators in support of their organization's continuous quality assurance and improvement systems, including managing their internal incident reporting system and comparing their data with statewide aggregate information.

Included in this document is a data analysis of all CIRs for all providers for 2014 including:

- Total number of persons supported by CHOICES waiver, CTS funding, and private ICF/IID funding;
- Total number of incident reports submitted;
- A breakdown of reports by category; and
- Information regarding the total statewide number of incidents by category.

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<sup>1</sup> CHOICES is the name of the Division of Developmental Disabilities' Home and Community Based Services Comprehensive Waiver. It is an acronym for Community, Hope, Opportunity, Independence, Careers, Empowerment, Success. In this report, the term HCBS will be used to reference the CHOICES waiver program.

The process for managing the CIR system is a joint collaboration between the DDD and each of South Dakota's CSPs. Each CSP is commended for fulfilling the responsibilities related to CIR notification to the DDD, submission of CIRs, and responsiveness to the DDD's requests for follow-up.

Each CSP is each assigned a Program Specialist who is responsible for reviewing all CIRs submitted by that CSP. DDD nurses review all CIRs that involve health, medication, injury, unplanned hospitalizations or medication issues. The DDD also has a CIR/QA team that coordinates a peer review process for all CIRs. The peer review process is designed as a quality assurance mechanism to ensure that all necessary follow-up is completed, timelines are met, and that any additional third party reporting (e.g., to the Attorney General's Medicaid Fraud Control Unit, Law Enforcement, Department of Social Services) has occurred. The peer review process has increased the DDD's ability to address CIR inconsistencies both internally and systemically.

The CIR/QA team also collects quarterly data and reviews trends by provider and CIR category. A root cause analysis process is used to determine areas of concern that might benefit from changes in policy and practice. A root cause analysis is a process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence of a sentinel event. As trends are identified, DDD Program Specialists are responsible for addressing issues with their assigned provider.

#### **SYSTEMS IMPROVEMENTS IN 2014**

1. CIR/QA team conducted two trainings to provide education to provider staff. One training included review of CIR Guidelines and basic reporting requirements, while the second training provided clarification regarding the online incident reporting system and correct categorization of incidents;
2. Program Specialists conducted technical assistance with five providers as training needs were identified by the providers or through the quarterly monitoring incident review and analysis;
3. DDD has provided further clarification regarding highly restrictive procedures (chemical, mechanical, and physical) definitions and specific reporting criteria;
4. DDD provided all CSPs with an Abuse, Neglect, Exploitation Reporting informational poster to be disseminated to the people they support and employees during a technical assistance and training webinar; and
5. Training has occurred on an ongoing basis for Program Specialists and provider staff to ensure reporting accuracy.
6. Data comparison of CIR system causes of death to all state-wide causes of death was completed and evaluated.

## REGULATORY AUTHORITY

The authority behind the submission of incident reports is as follows:

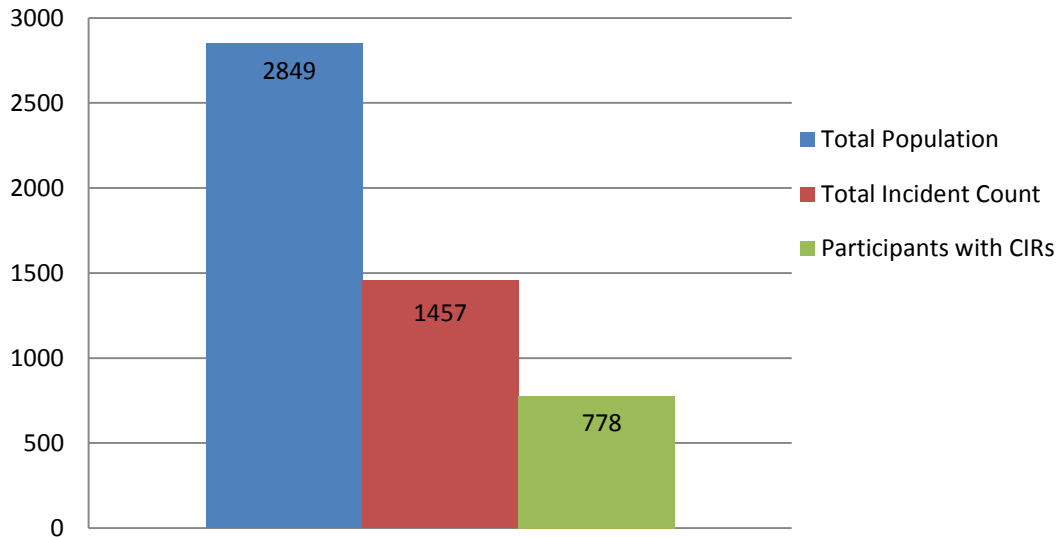
*Administrative Rule of South Dakota 46:11:03:02. Critical incident reports – Submission to division.* The CSP shall give verbal notice of any critical incident involving a participant to the division no later than the end of the division's next business day or the CSP's administrative business day whichever occurs first from the time the CSP becomes aware of the incident. The CSP shall submit a written critical incident report utilizing the division's on-line reporting system within seven calendar days after the initial notice is made. A report must be submitted for the following:

- (1) Deaths;
- (2) Life-threatening illnesses or injuries;
- (3) Alleged instances of abuse, neglect, or exploitation against or by any participant;
- (4) Changes in health or behavior that may jeopardize continued services;
- (5) Serious medication errors;
- (6) Illnesses or injuries that resulted from unsafe or unsanitary conditions;
- (7) Any illegal activity involving a participant;
- (8) Any use of physical, mechanical, or chemical intervention, not part of an approved plan;
- (9) Any bruise or injury resulting from the use of a physical, mechanical, or chemical intervention;
- (10) Any diagnosed case of a reportable communicable disease involving a participant; or
- (11) Any other critical incident as required by the division.

The report must contain a description of the incident, specifying what happened, when it happened, and where it happened. The report shall also include any action taken by the CSP necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the CSP to reduce the likelihood of similar incidents occurring in the future. The division may request further information or follow-up related to the critical incident.

The CSP shall notify the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, that a critical incident report has been submitted and the reason why unless the parent or guardian is accused of the incident.

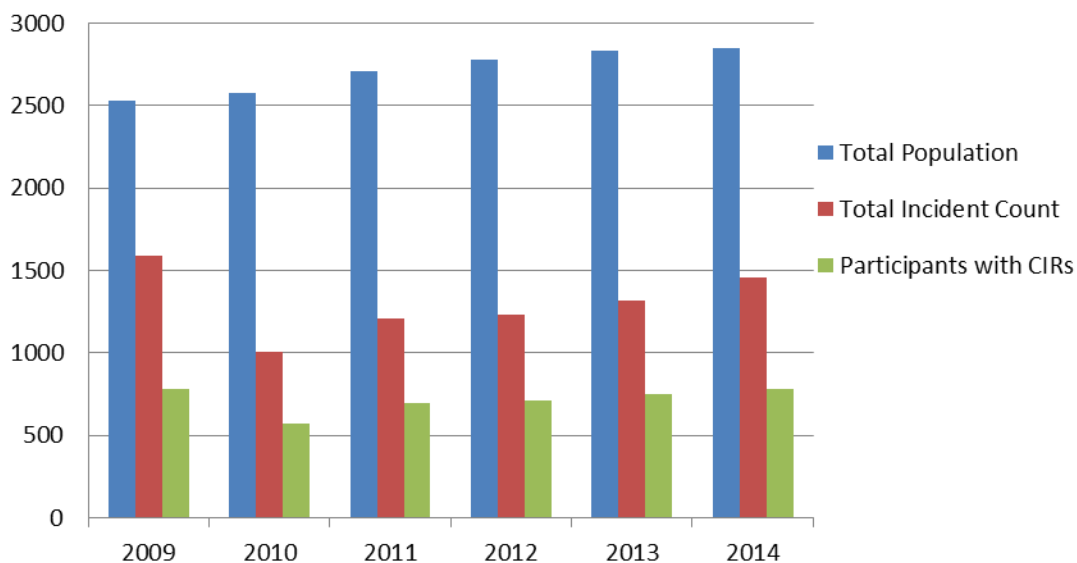
## 2014 Total Number of Incidents



In 2014, the number of persons supported through HCBS, CTS and Private ICF/IID funding increased by 12, and the number of participants for whom critical incidents were reported also increased by 31 participants from 2013.

The total incident count for 2014 was 1,457, an increase of 138 incidents from the previous year. These incidents were submitted for 778 participants, or 27.3% of all participants in South Dakota receiving supports and services through CHOICES, CTS or Private ICF/IID.

## 2009-2014 Total Number of Incidents

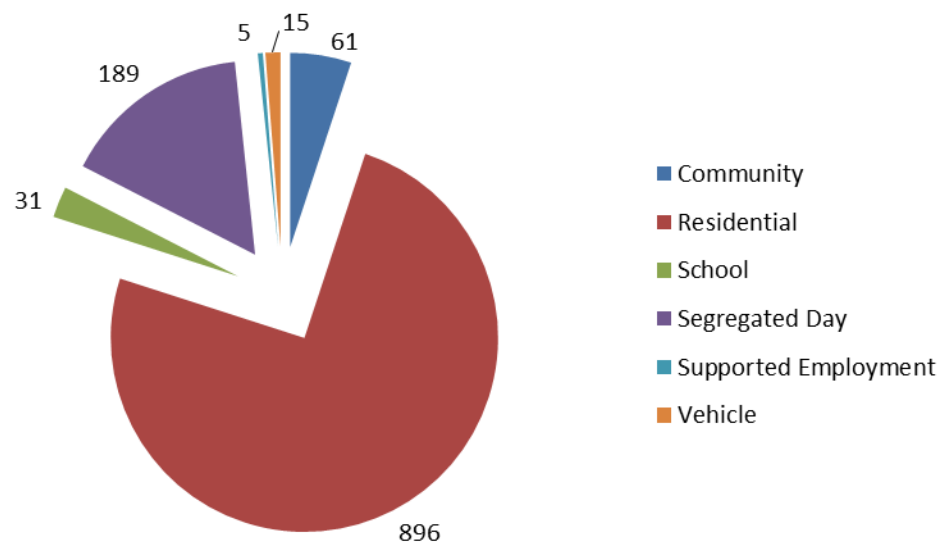


	Total Population	Total Incident Count	Participants with CIRs	% of Participants with CIRs
<b>2009</b>	2528	1594	782	30.93%
<b>2010</b>	2575	1004	572	22.21%
<b>2011</b>	2707	1213	698	25.79%
<b>2012</b>	2776	1234	711	25.61%
<b>2013</b>	2837	1319	747	26.33%
<b>2014</b>	2849	1457	778	27.31%

The total population of participants supported in South Dakota has grown on average per year by 64 participants since 2009. The total population has increased overall in the past six years. Although there was an increase in incidents in 2014, this may be attributed to the fact that the number of participants has increased; as well as supporting people with more challenging needs, therefore multiple CIRs are reported for those people.

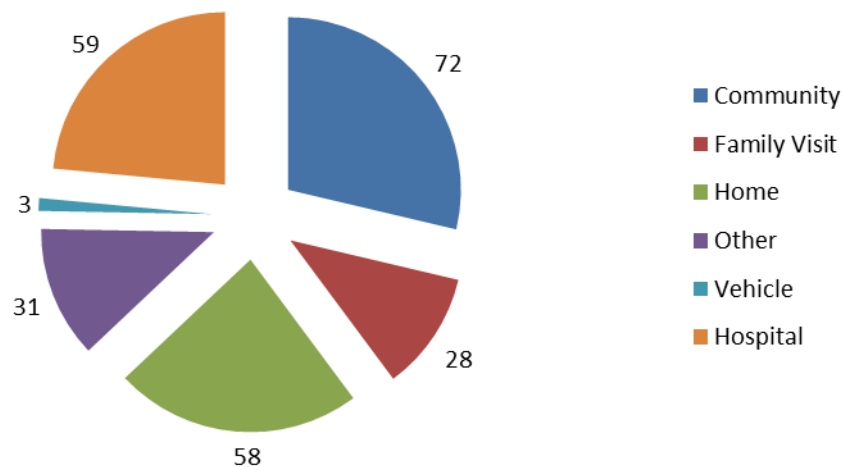
The table above reflects the fluctuation in population, incident count, and number of participants for whom CIRs were reported. The difference in the number of total incidents versus the number of participants is due to the fact that several CIRs may be submitted for the same participant throughout the year. The column “% of Participants with CIRs” is calculated by dividing the number of participants with CIRs by the total number of participants.

### 2014 Location when in Provider Support



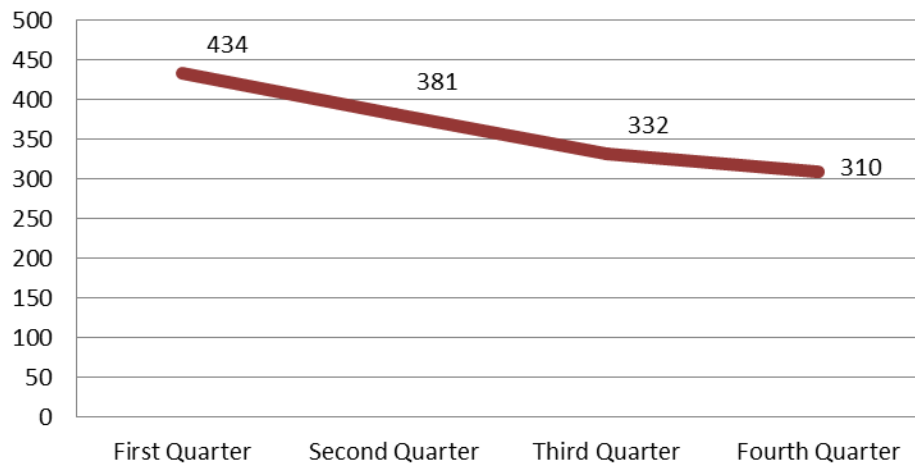
While receiving provider support, incidents primarily occur at residential settings and segregated day settings. Participants are likely spending most of their time in these environments, as 896 incidents occurred in residential settings and 189 incidents occurred in segregated day settings. Significantly less incidents occur while participants are at other locations in the community, supported employment, school, and in vehicles. The data may also indicate that incidents are less likely due to the training that has occurred with providers and staff, as well as peer reviews and follow up by the Program Specialist to ensure accuracy.

### 2014 Location when not in Provider Support

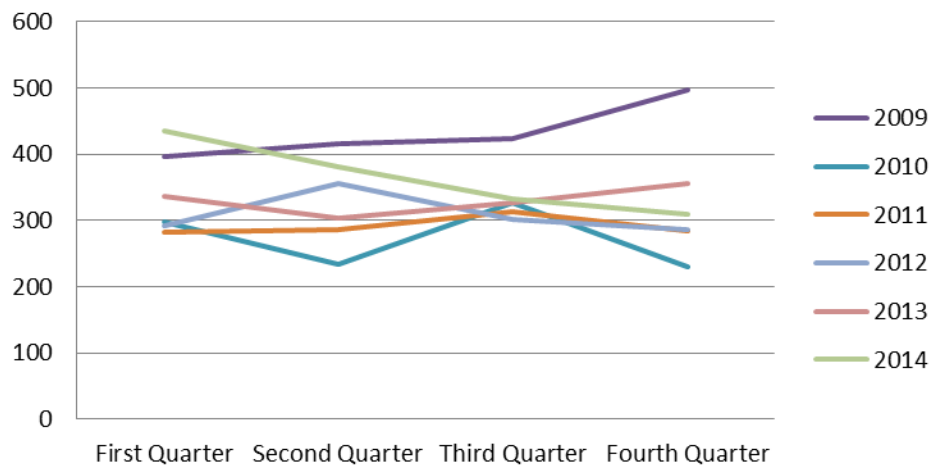


Incidents that occur while people are outside of provider support happen most frequently in the “community” with 72 reports. This data reflects that participants are accessing the community by themselves or with natural support networks and includes a variety of locations. Fifty-eight incidents occurred while people were at home, which encompasses participants who reside in a supported living environment and receive minimal residential supports as well as participants who live in a home with family members. Thirty-one incidents occurred at “other” locations, which include, but are not limited to, clinics, hospitals, and local events/businesses. In 2014, all areas of this above graph increased with the exception of Other, which decreased by 19.

## 2014 Quarterly Reporting



## 2009-2014 Quarterly Reporting

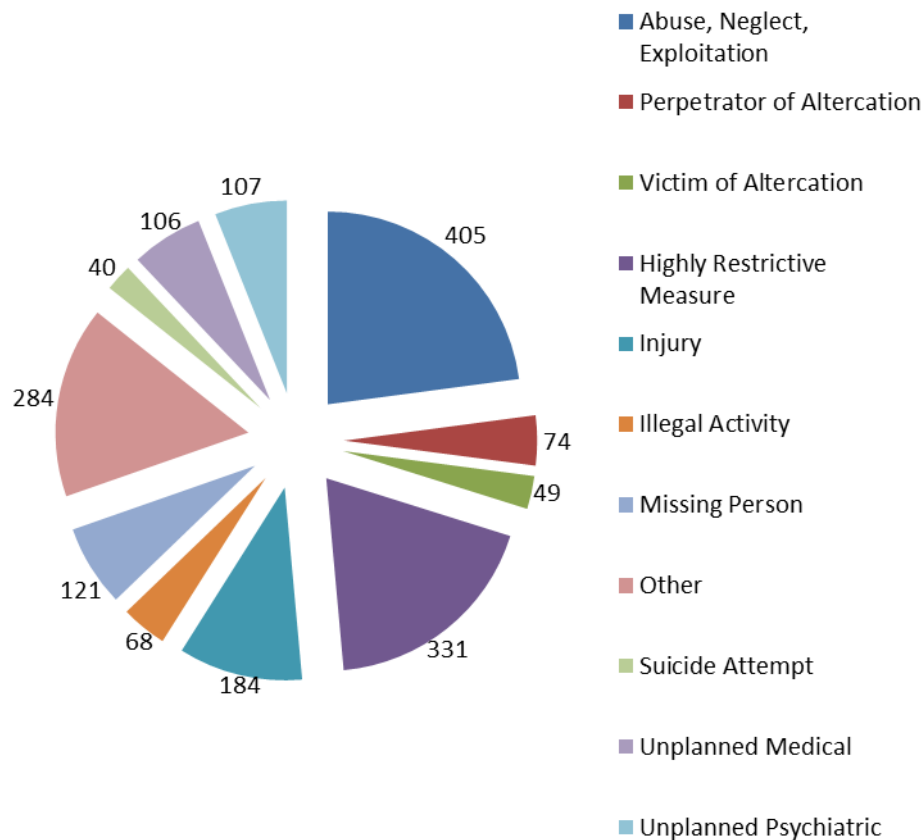


	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
2009	397	416	424	496
2010	298	234	326	229
2011	282	285	313	284
2012	291	356	301	286
2013	337	303	327	356
2014	434	381	332	310



In the graph on the previous page further analysis conducted and revealed that there were many system improvements relating to CIRs including updated CIR guidelines, CIR/QA team began evaluating the process for which peer reviews, quality assurance and quarterly incident reviews are completed, CHOICES waiver manager joined the CIR/QA team and formal training for new and existing DDD staff was developed and implemented.

## 2014 Incident Categories



In 2014, the Critical Incident Reporting category most frequently reported to DDD was Abuse, Neglect and Exploitation (ANE) with 405 incidents. This is an increase of 34 reports from the previous year's data. The second highest category reported was Highly Restrictive Measures category, with 331 incidents.

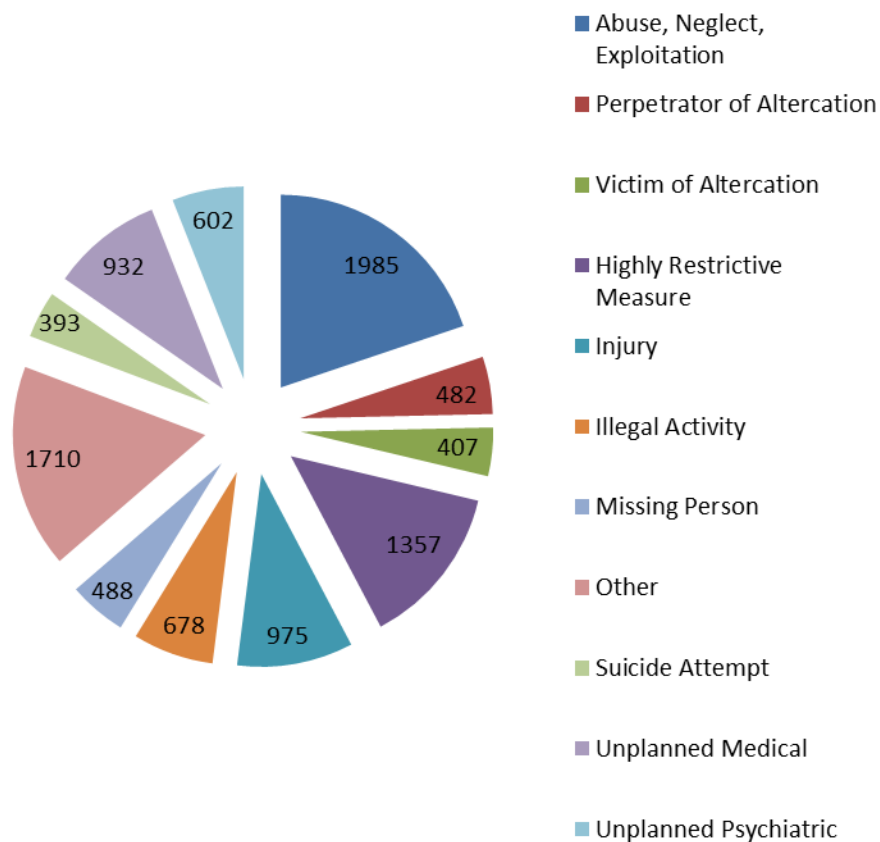
Other category was the third most frequently reported with 284 incidents, followed by Injury (184). The Other incident category includes:

- Community Complaint;
- Increase in Behavioral Issues;
- Jeopardizing Personal Safety;

- Jeopardizing Services;
- Medical Diagnosis;
- Medication Error;
- Use of Illegal Substances;
- Vehicle Accident;
- Victim of Fire;
- Victim of Theft; and
- Communicable Disease.

The category with the lowest number of incidents reported to the DDD was Suicide Attempt with 40 reports. The number of incidents in the following categories reflects a decrease from previous years' data: Victim of Altercation, Suicide Attempt, Unplanned Medical, and Unplanned Psychiatric categories.

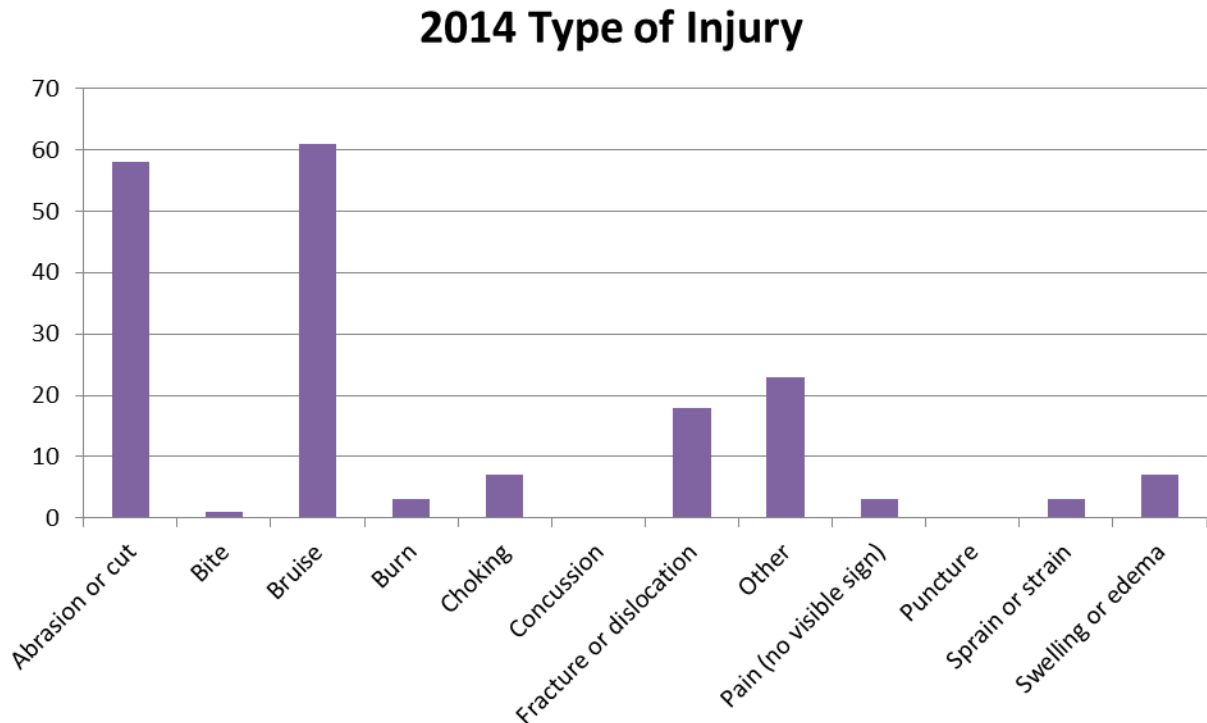
## 2009-2014 Incident Categories



Incident reporting trends for 2009 through 2014 are consistent with 2014 reporting with ANE and Other being the most frequently reported incidents over the past six years. ANE reporting has ranged from 217 reports in 2010 to 405 reports in 2014, with an average of 397 incidents between 2009-2014.

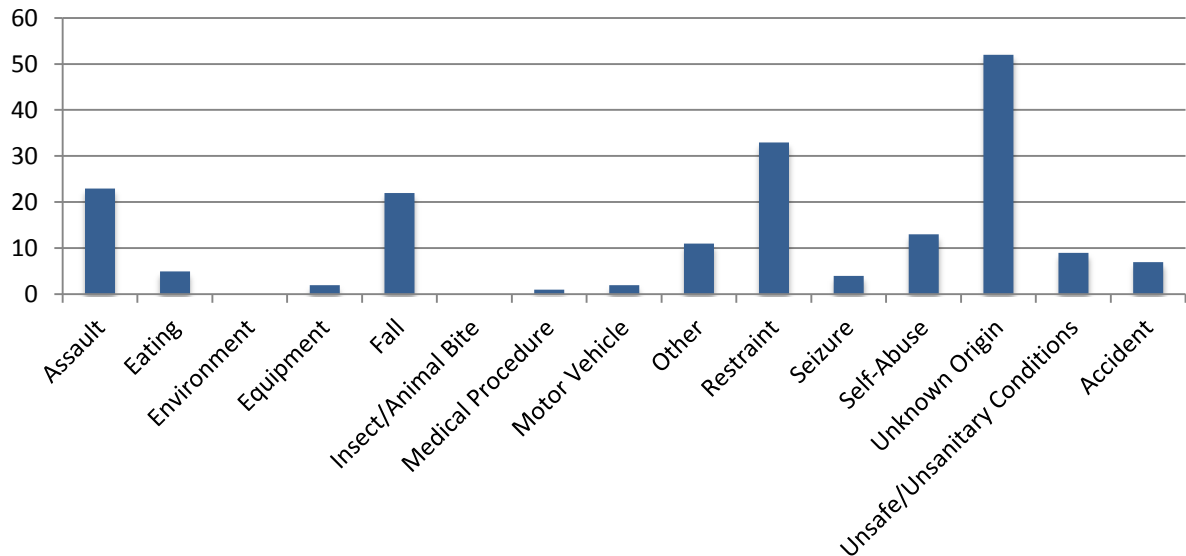
Incidents in the Highly Restrictive Measures category total 1,357 from 2009 through 2014. Reporting in this category has generally increased since 2009.

## INJURY:



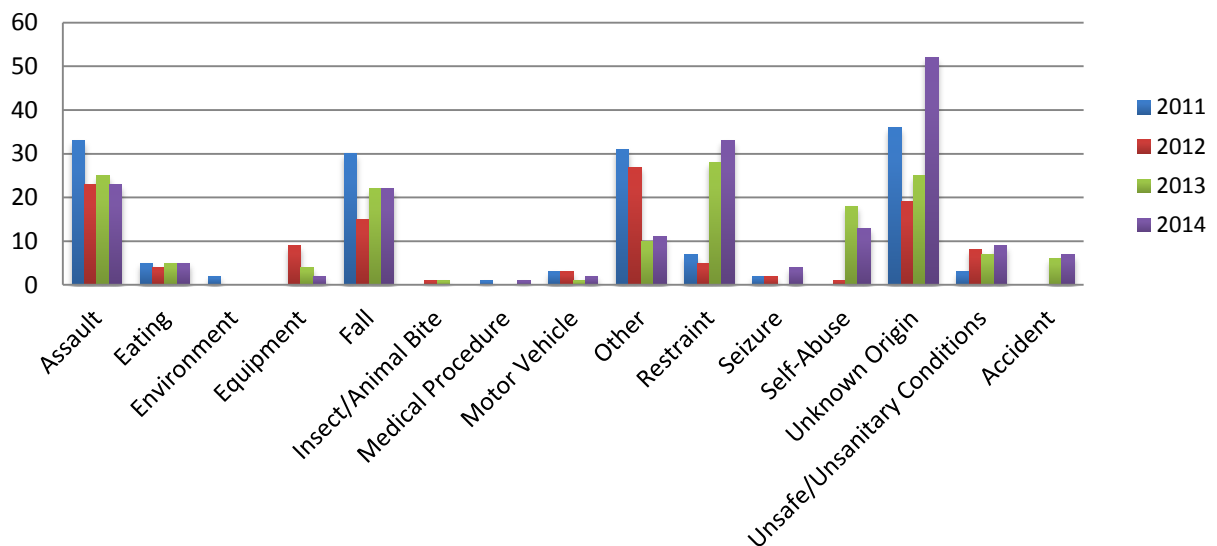
In 2014 there were 184 injuries reported to DDD. The most frequently reported injuries are Bruise (61), Abrasion or cut (58), Other (23) and Fracture or dislocation (18). There were 23 “Other” types of injuries reported to the DDD, these types of injuries include but are not limited to: choking, concussion, bites, and burns. Five of the 23 incidents reported in Other were inaccurately categorized. Those reports should have been categorized as Abrasion/cut, Bruise, and Pain (no visible sign). in the Other Type of Injury.

## 2014 Cause of Injury



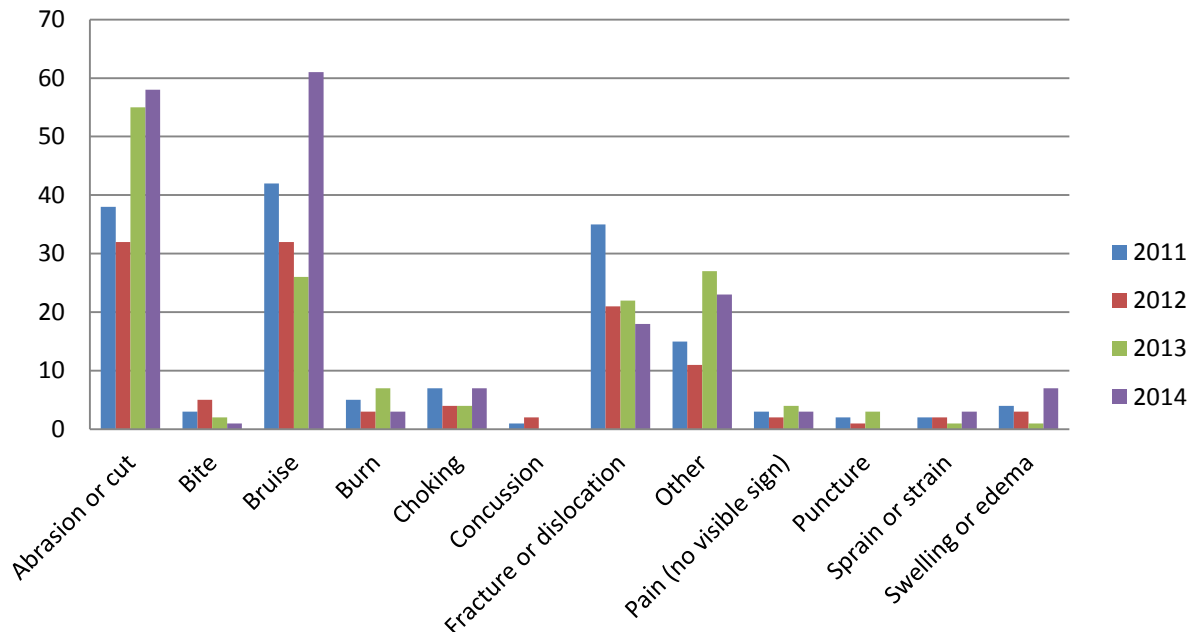
Cause of Injury data reflects Injuries of Unknown Origin as the most frequently reported category reported to the DDD, with 52 reports in 2014. Other top causes of Injury are Restraint (33), Assault (23) and Fall (22). This information seems to correlate with the leading types of injuries which are Bruises, Abrasion/cut, and Fracture/dislocation. Eleven incidents identified as Other within Cause of Injury were reviewed by the DDD. Through this review, it was determined that six of these were incorrectly categorized and would of better fit under the categories of Restraint, Fall and Self-Abuse. There were two incidents that the cause was not a cause but a type.

## 2011-2014 Cause of Injury



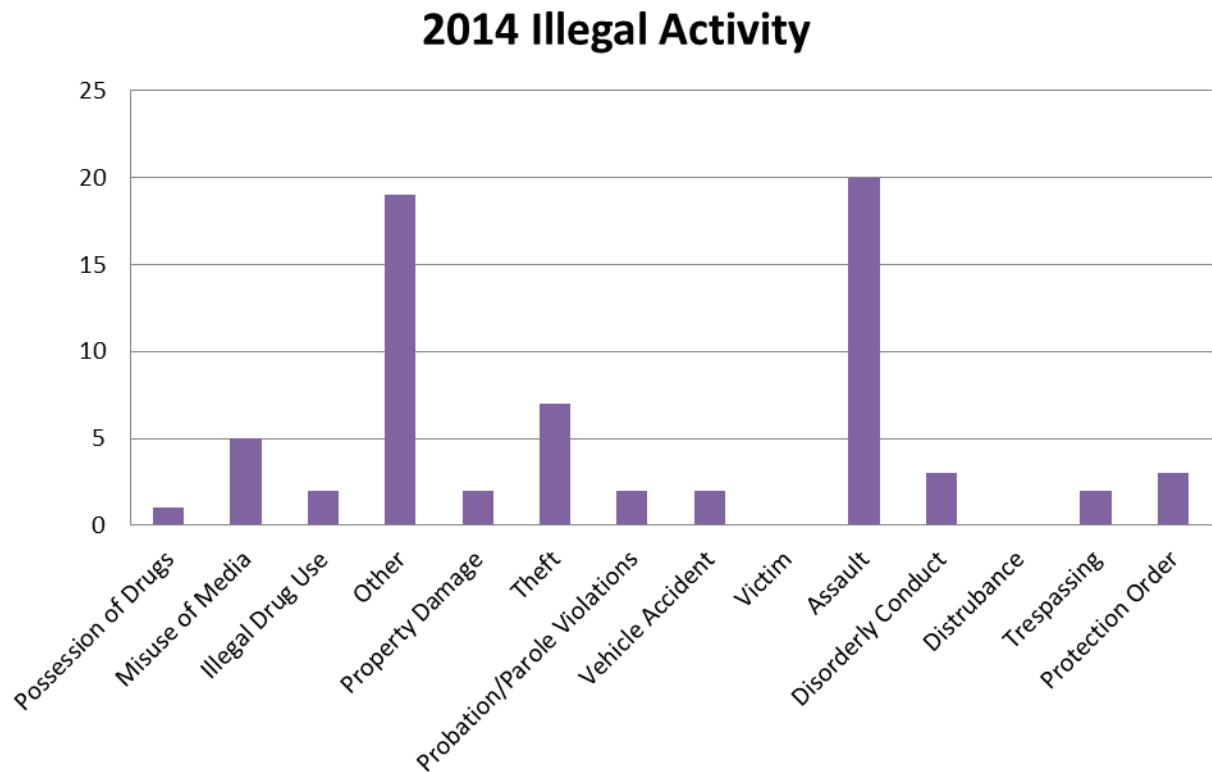
From 2011-2014 the leading causes and types of injuries have remained consistent. In 2014 there were four categories resulted in an increase: Unknown Origin, Restraint, Unsafe/Unsanitary Conditions and Motor Vehicle. In 2014 clarification was provided that injuries of unknown origin may or may not be considered to be ANE and that in circumstances injuries of unknown origin is more appropriate when injuries are not suspicious nature.

## 2009-2014 Type of Injury



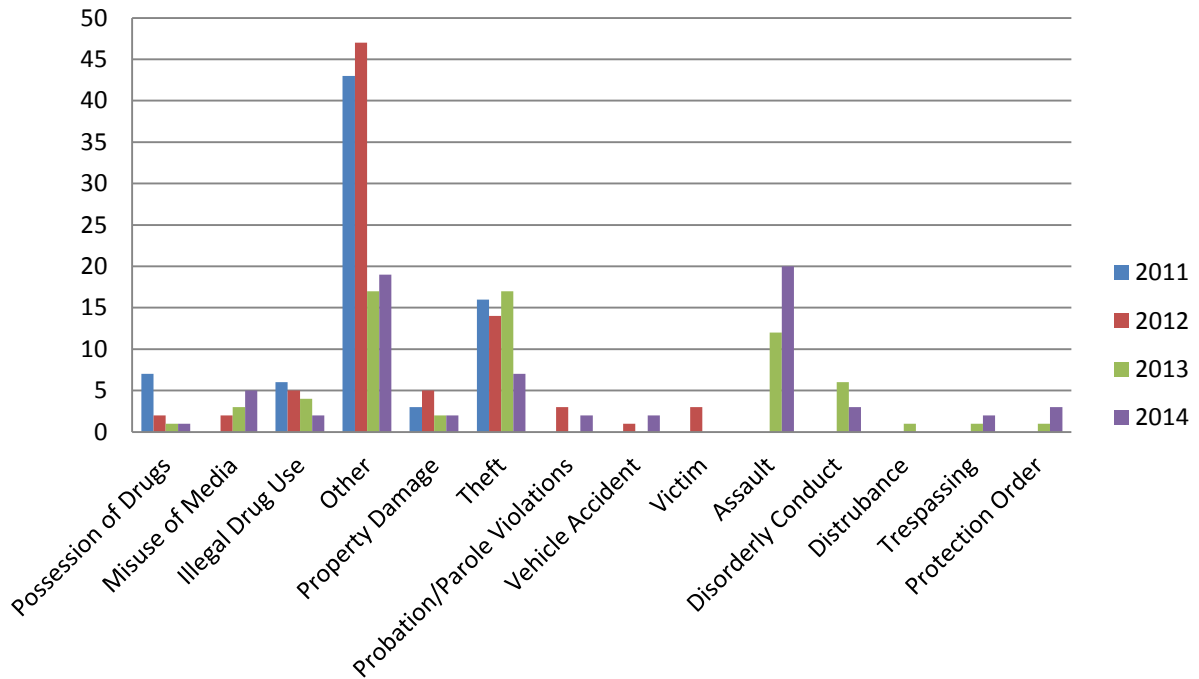
From 2009-2014 the leading types of injury are consistent with the 2014 data. There were increases from the previous year's data in the following categories: Abrasion or cut, Bruise, Choking, Sprain or Strain and Swelling or edema.

## ILLEGAL ACTIVITY:



In 2014, the category with the largest increase was Assault with 20 incidents. Some of the incidents identified as “Other” were related to resisting arrest, false reporting, identify theft, domestic violence. There were two trends that emerged from this analysis, those are alcohol related incidents and financial related incidents. The CIR/QA team will determine if this trend is enough to add another category. There were no incidents reported for Disturbance, and Victim of Fire.

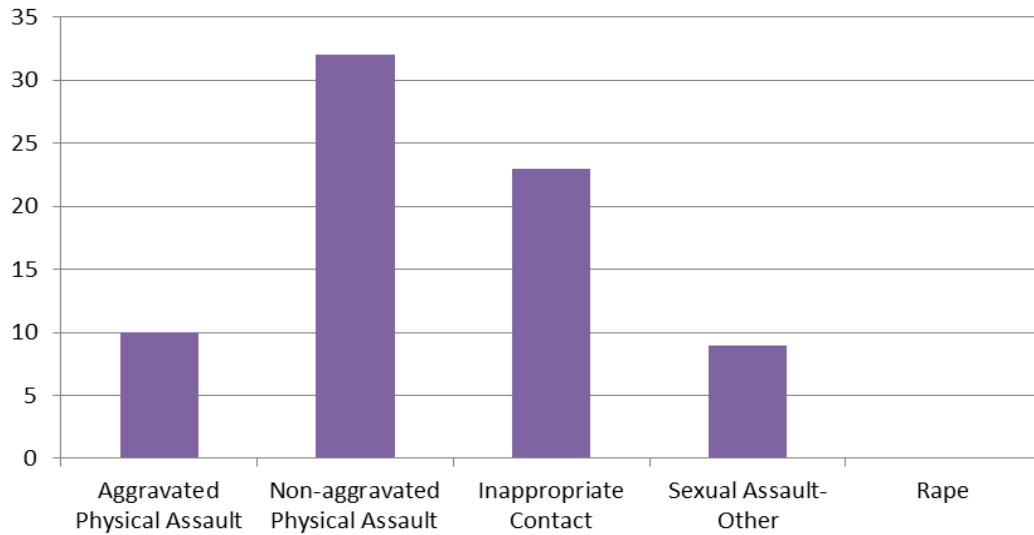
## 2011-2014 Illegal Activity



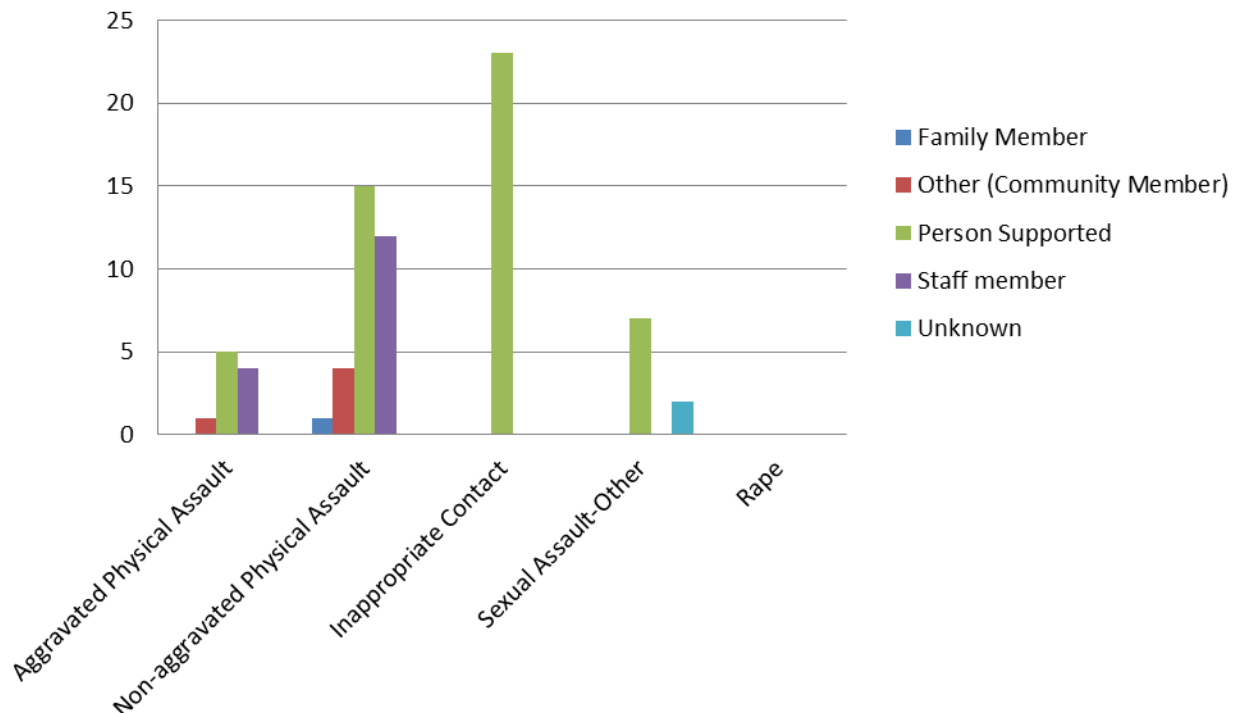
Illegal Activity incidents reported in 2014 totaled 68; with 39 of these reports being identified under the category of Assault (20) and Other (19). Incidents identified as “Other” have significantly decreased over the past several years; however, reporting in this sub-category in 2014 was slightly higher than in 2013. Further analysis of the increase in Assault resulted in five CSPs noting an increase between one and three incidents in 2014.

## ALLEGED VICTIMS/PERPRETRATORS OF ALTERCATIONS:

### 2014 Alleged Victim of Altercation

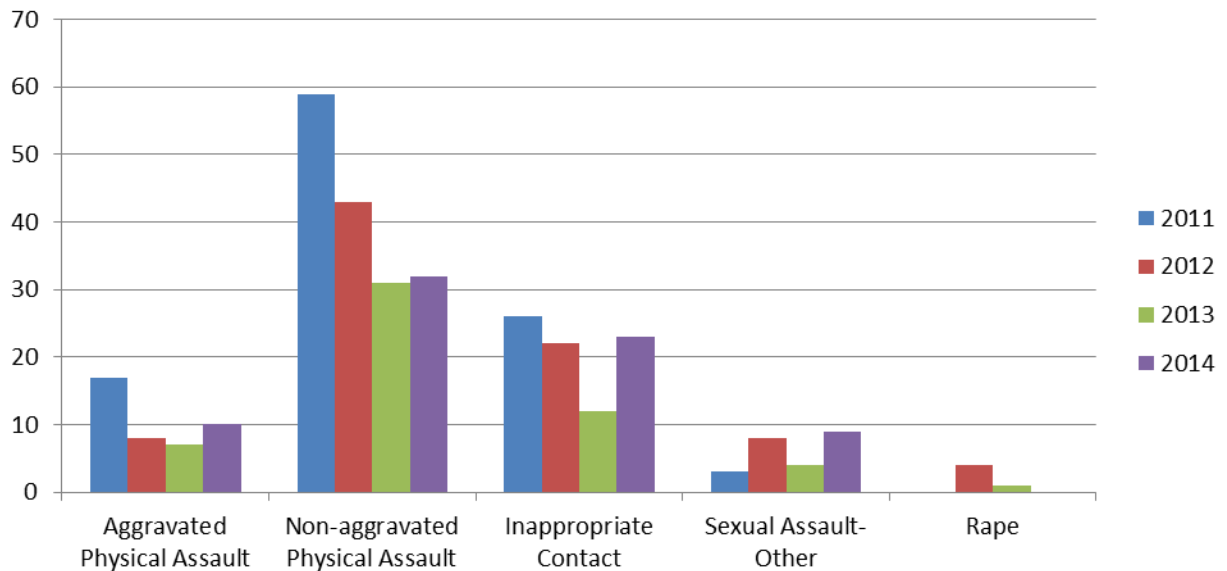


### 2014 Alleged Victim by Type of Altercation





## 2014 Alleged Victim of Altercation

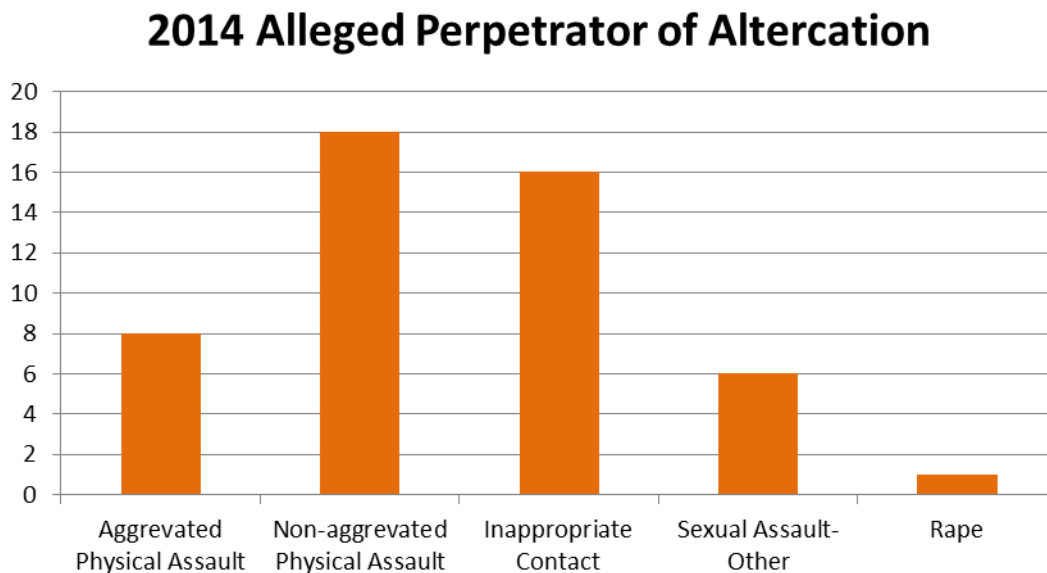


The report demonstrates who the perpetrators were for each type of altercation under the Alleged Victim section of the online CIR form.

The most frequently reported types of altercations are Inappropriate Contact between two participants. This relates to the data indicating that incidents happen most frequently in residential and segregated settings where participants are in close proximity to each other. Non-aggravated Assault and Inappropriate Contact incidents were reported most frequently with 32 reports and 23 reports, respectively. Inappropriate contact increased by 11 reports. Further analysis of this discovered no trends in provider specific reporting.

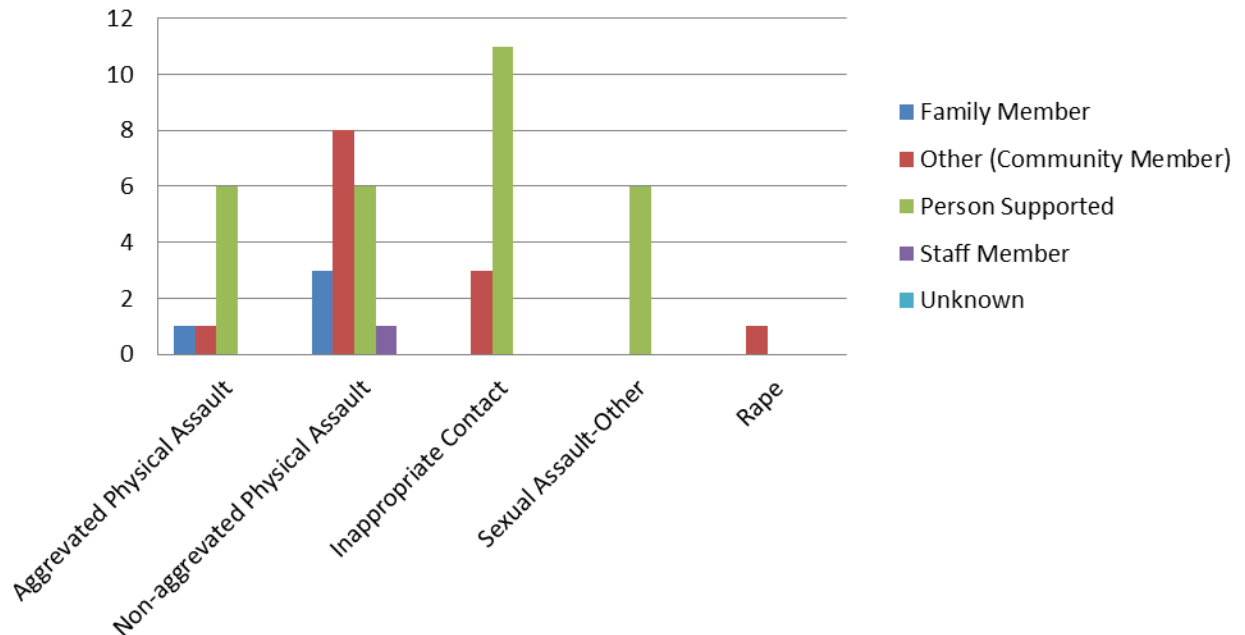
## ALLEGED PERPRETRATOR/VICTIM OF ALTERCATION:

The information below indicates that there were 18 incidents in which a participant was the Alleged Perpetrator of Non-aggravated Physical Assault, 16 incidents of Inappropriate Ccontact allegations, eight Aggravated Physical Assault allegations, six Sexual Assault-Other allegations, and one incident where participants were accused of Rape. Inappropriate contact increased by ten reports while Non-aggravated Physical Assault reamined the same. Further anaylsis of the increase in Inappropriate Contact identified that five CSPs reported an increase, however each was less than three.



The number of altercations reported in 2014 in which a participant was the perpetrator of an altercation is reflected in the graph above. The total number of reports in this area is considerably lower than the number of reports submitted in which a participant was the victim.

## 2014 Alleged Perpetrator by Type of Altercation

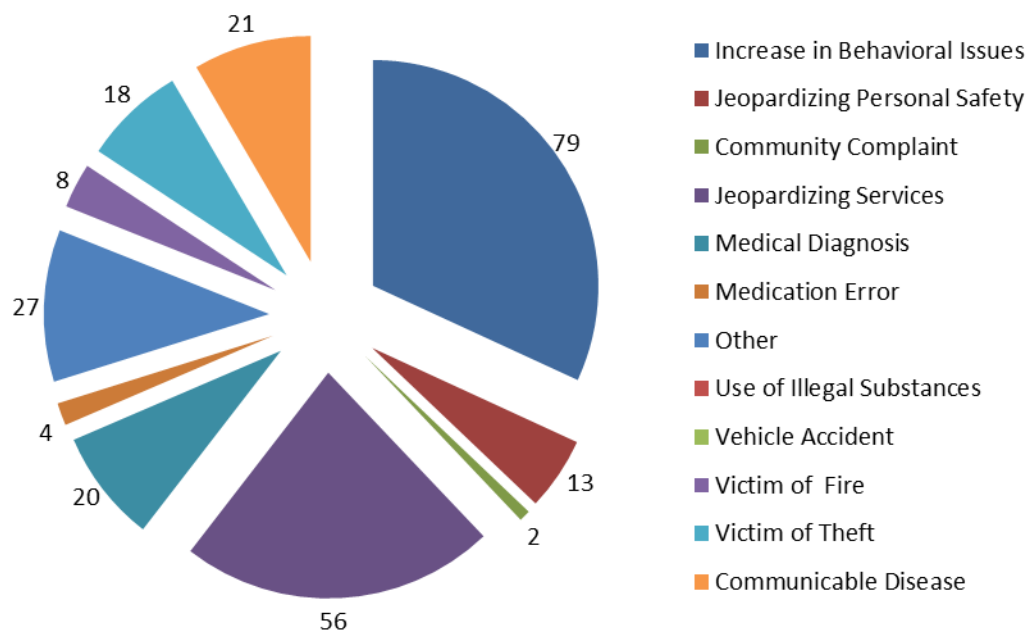


The report above demonstrates the victims for each type of altercation under the Alleged Perpetrator section of the online CIR form. Reports for People Supported are the highest in three of the five categories. The second most frequently reported Victim group is Other or Community Member.

The two most frequently reported types of altercations are Non-aggravated Physical Assault and Inappropriate Contact.

## OTHER:

### 2014 Other Incident Breakdown



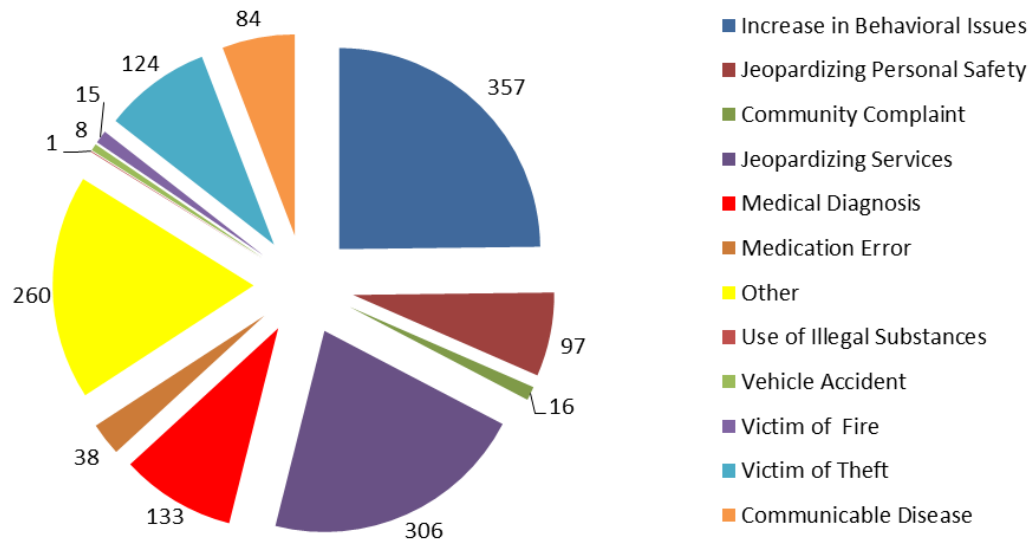
There are total of 248 CIRs that fell into the “Other” incident category during 2014. These included various reports, ranging from Communicable Disease to Victim of Theft. Of the total number, 79 incidents due to an Increase in Behavioral Issues, followed by 56 reports of Jeopardizing Services, 27 reports categorized as Other, 21 reports of Communicable Disease were reported, 20 were categorized as Medical Diagnosis, 18 were Victim of Theft, and 13 Use of Illegal Substances were reported. Twenty-seven of these reports are unique and do not align with any single category and were indicated as Other. Some examples of these reports are:

- Intoxication,
- Police Involvement- no arrest/charge, and
- Suicide threat with no plan or means to follow through.

Upon review of the unique reports it is clear that some were categorized incorrectly. Of the 27 reports in the “Other-Other” category, most should have been categorized in another sub-category, these categories include: Physical Abuse, Victim of Theft, and Injury. The incorrectly categorized incidents result in an increase from 2013 when four incidents were incorrectly captured within the “Other-Other” category. The CIR/QA team has provided follow up and technical assistance to those providers which have incorrectly categorized incidents, as well as with DDD staff to ensure consistency during peer review of incidents.

In 2014 there were three categories that reported an increase from 2013; those include Increase in Behavioral Issues by 32, Other-Other increased by 15 and Jeopardizing Services increased by nine. All other categories decreased by at least seven and the largest decrease occurring in Communicable Disease with 20 fewer reports.

## 2009-2014 Other Incident Breakdown

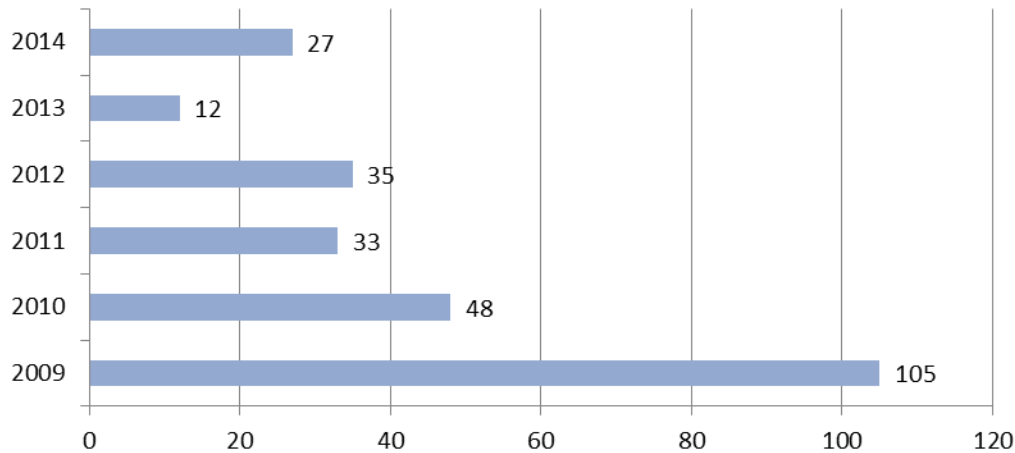


From 2009 through 2014, reports in the Other Incident category totaled 1,439, a decrease from 2008-2013 reporting period. A majority of these incidents (357) were categorized as Increased in Behavioral Issues. The second most frequently reported category is Jeopardizing Services (306), followed by Other-Other (260).

In 2005 when the CIR method was originally implemented many incidents were being categorized as Other-Other. As DDD and CSP staff became better informed and other options have been added within the online reporting form, incidents are categorized more accurately.

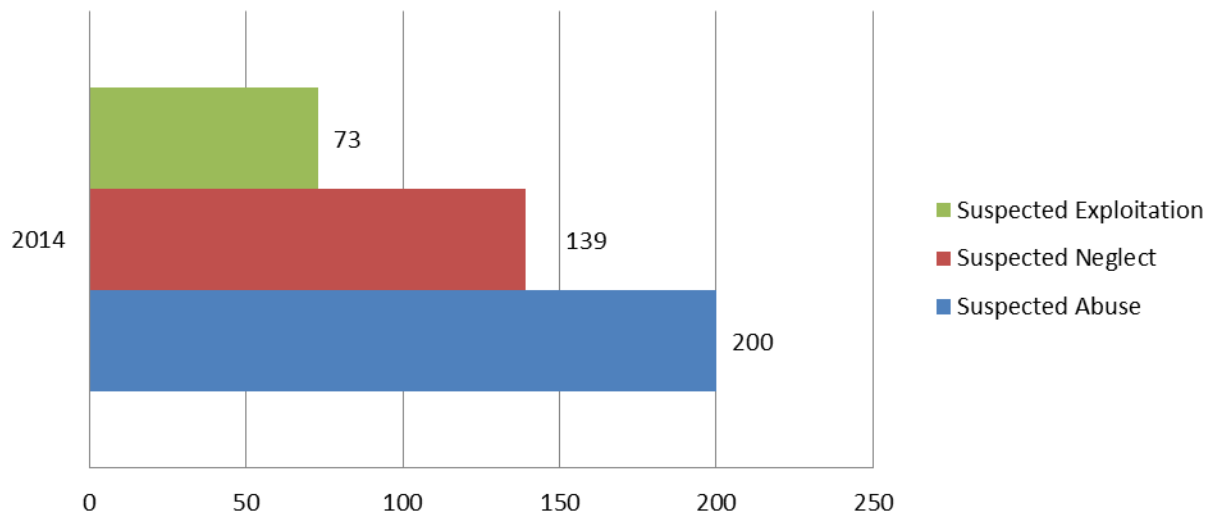
The graph on the next page reflects the fluctuations in reporting under the Other-Other category. Between 2009 and 2014, the number of Other-Other incidents fluctuated between increases and decreases. DDD continues to monitor and provide training to CSPs regarding categorization of incidents.

## 2009-2014 Other-Other Incident Reports



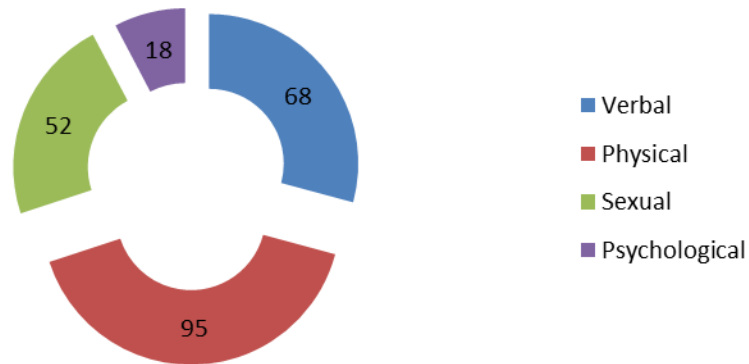
### ABUSE, NEGLECT AND EXPLOITATION:

## 2014 Abuse, Neglect and Exploitation Reporting



Incident reporting in the ANE category for 2014 was as follows: 200 Abuse allegations, 139 Neglect allegations, and 73 Exploitation allegations. Suspected Abuse has historically been more frequently reported than neglect and exploitation. Within the CIR form, reporters are required to specify whether the Abuse was Verbal, Physical, Psychological, or Sexual which is reflected in the graph below. It is noted that the total number of Verbal, Physical, Sexual and Psychological allegations equal 233, whereas 200 allegations of Abuse incidents were submitted. This is due to providers having the option to choose more than one type of alleged Abuse within a single incident form.

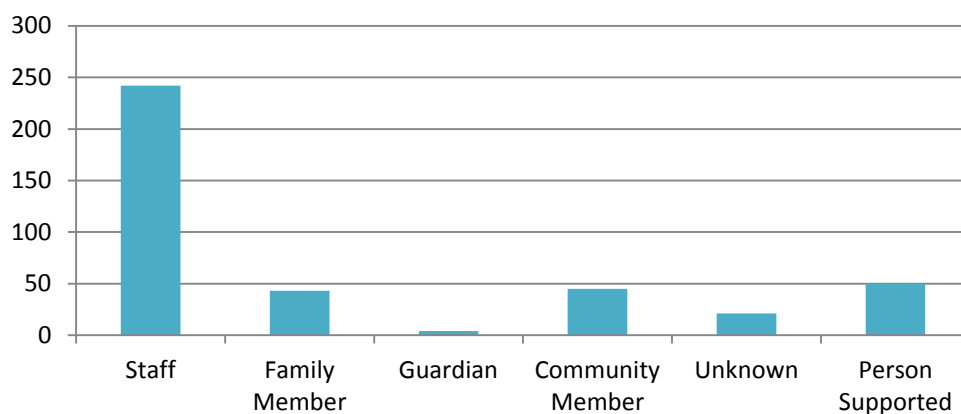
## 2014 Abuse Type



As the graph above indicates, the number of allegations of Physical Abuse is substantially higher than other types of Abuse at 95 allegations, followed by allegations of Verbal Abuse at 68 reports. Sexual and Psychological allegations are the lowest at 52 and 18 reports, respectively.

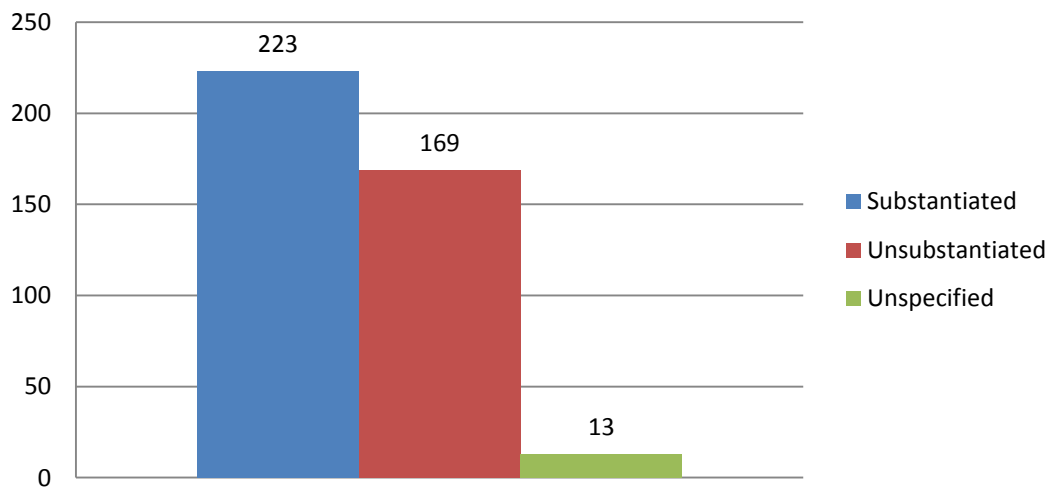
In the graph below a total of 412 ANE allegations were made in 2014. Of those, 242 were against staff members; 50 were against other participants using supports; 45 were against Community Members; 43 allegations were against Family Members; 21 were Unknown; and 4 allegations were made against Guardians.

## 2014 Suspects of Abuse, Neglect and Exploitation

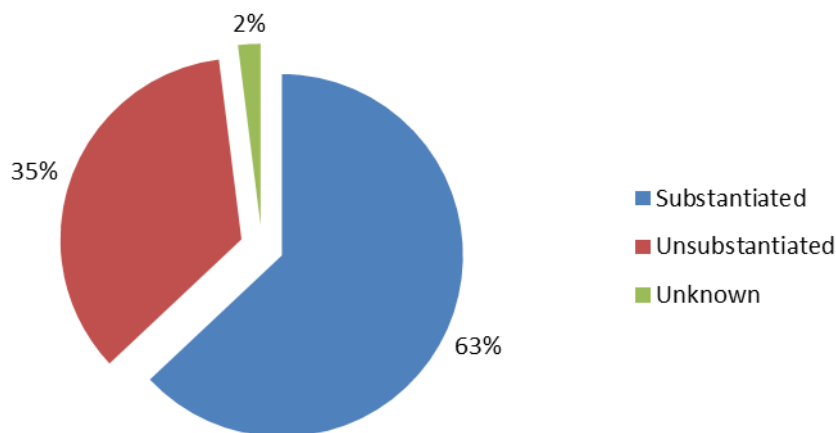


In 2014, 223 allegations were Substantiated, 169 were Unsubstantiated and 13 were Unspecified. Unspecified is an indication that the Program Specialist marked neither the Substantiated nor the Unsubstantiated section while reviewing the CIR online report. Follow up will occur with Program Specialists to ensure incidents are accurately categorized. The data shows a 54% Substantiation rate among all reported allegations of ANE.

### 2014 Abuse, Neglect and Exploitation Substantiation



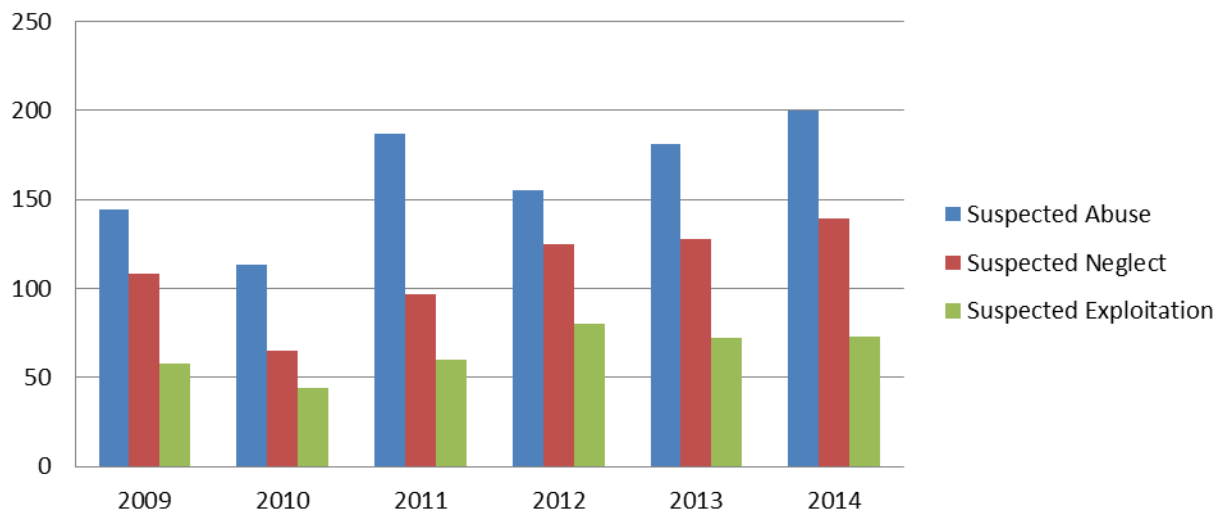
### 2014: Abuse, Neglect and Exploitation by Staff





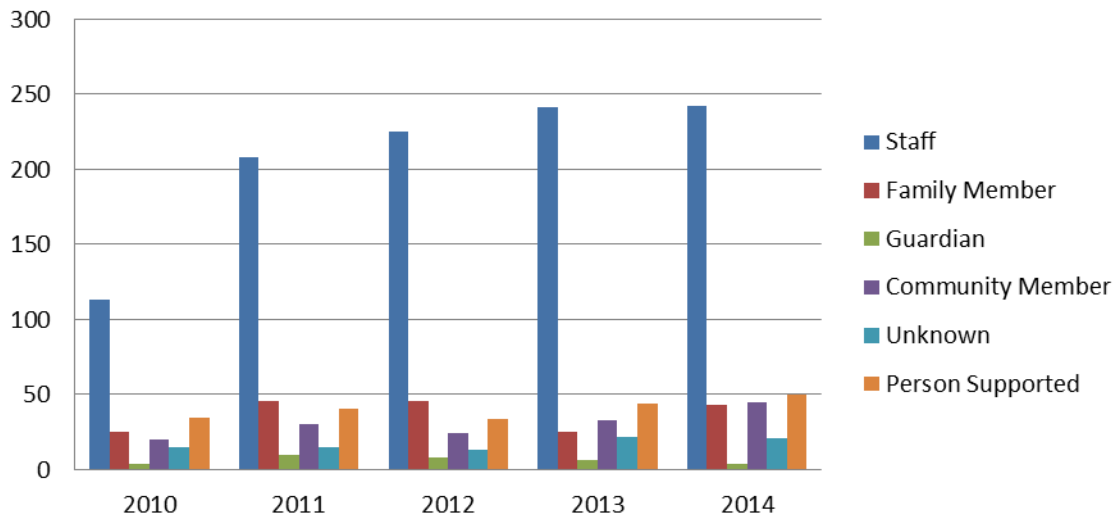
A total of 242 total incidents were reported for ANE against staff providing services and supports in provider agencies. Of the 242 reported incidents 152 were Substantiated, 85 were Unsubstantiated and five were Unknown. After further analysis of the five incidents that are categorized as neither Substantiated nor Unsubstantiated, it was determined that investigations conducted by the provider were inconclusive. Training was provided in December of 2014 to CSPs regarding these reports.

## 2009-2014 Abuse, Neglect and Exploitation Reporting



It should be noted that the total highest reporting for all three categories was in 2014 and has gradually increased since 2012. In 2014, suspected Abuse allegations increased by only 19 reports from 2013 which was the smallest increase since 2011.

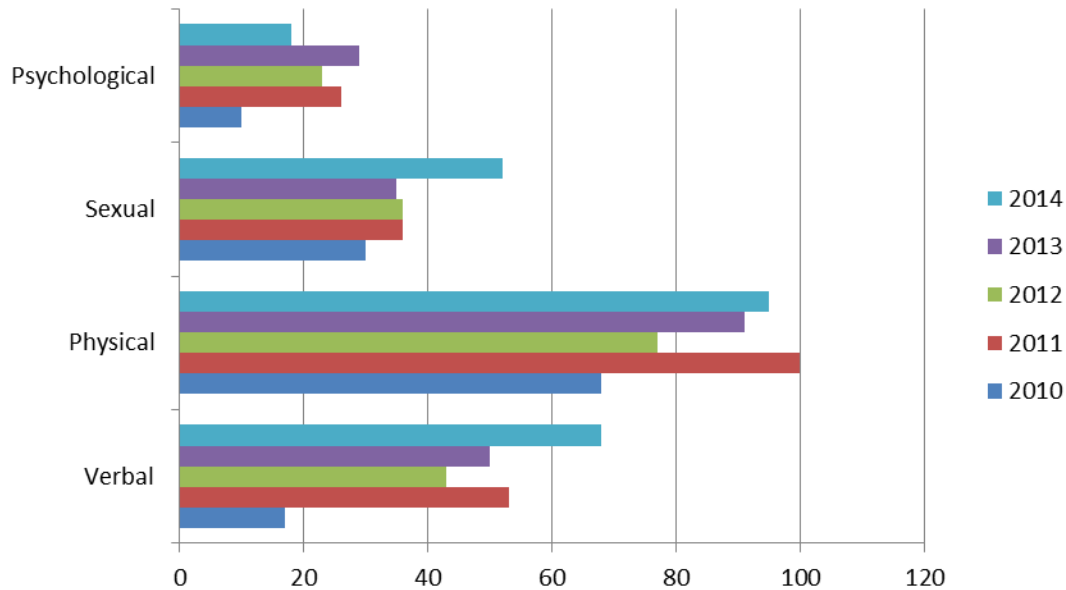
## 2010-2014 Suspects of Abuse, Neglect and Exploitation



In 2014, incidents of ANE increased by 31 incidents from 2013. Allegations against Community Member and Unknown decreased. All other “Suspected by” categories increased. Incidents in which staff was accused of ANE totaled 242, an increase of only one incident from 2013.

From 2010-2014 the most reported allegation was suspected by Staff reporting 1,029 reports. The other categories included Person Supported (204), Family Member (185), Community Member (152), Unknown (86) and Guardian (32). Data collection for these categories began in 2010.

## 2010-2014 Abuse Type



Increased reporting occurred in most categories of Abuse in 2014, with the exception of Psychological Abuse which decreased by 11. In 2014, allegations of Verbal Abuse increased by 18, Sexual Abuse increased by 17 incidents, and Physical Abuse increased by 4 incidents.

## 2009-2014 Abuse, Neglect, and Exploitation Substantiated

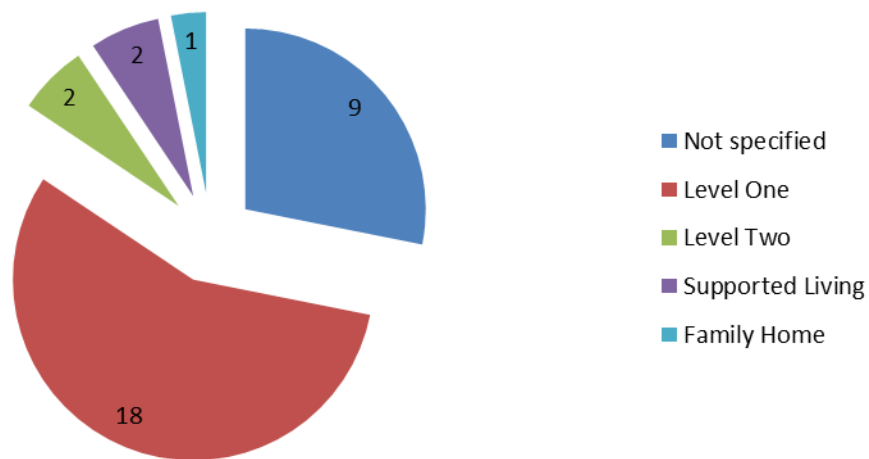


Since 2009, the trend of substantiation of ANE allegations has remained relatively consistent, with the lowest substantiation rate of 48% in 2010 and the highest substantiation rate of 61% in 2011. The DDD will continue to monitor these trends and provide technical assistance regarding investigations to providers as necessary.

## MORTALITY ANALYSIS:

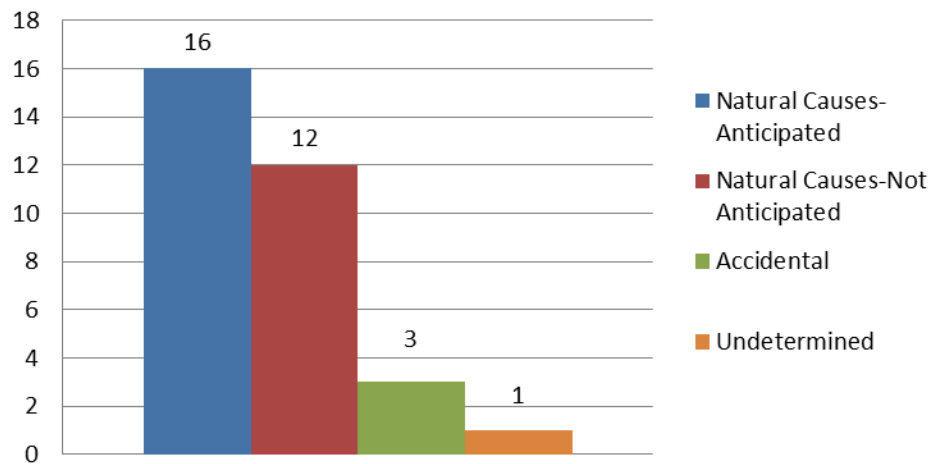
By definition, state developmental disability systems support people from an early age until the end of life. Supporting individuals through the end stages of their life is a critical function that CSPs provide to participants. In South Dakota, the relatively low number of deaths each year makes it difficult to detect annual trends. The DDD reviews all deaths and may conduct investigations of any deaths that are accidental, unexplained, or occur amidst allegations of abuse or neglect.

### 2014 Level of Residential Support



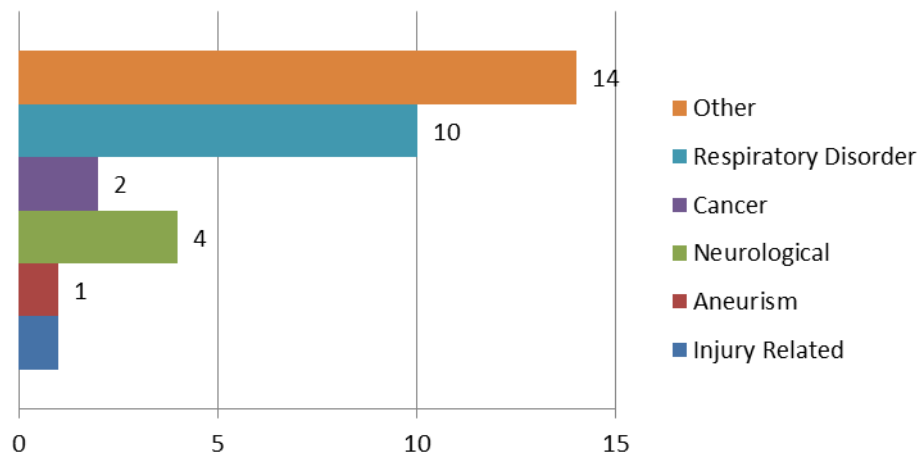
In 2014, there were 32 deaths reports submitted by CSPs. Of these, 18 participants were receiving residential supports in a Group Home (Level One) setting and two in each Supervised Apartment (Level Two) and Supported Living (Level Three). Instances in which the level of supervision is “Not Specified,” indicates that the participant did not receive residential supports from the CSP but received at least one other waiver service, CTS or private funding.

## 2014 Type of Death



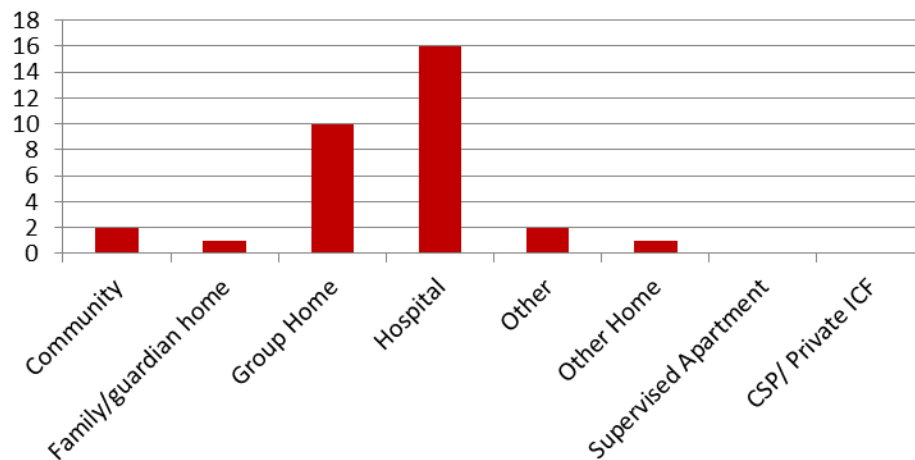
As seen in the graph above, sixteen deaths in 2014 were due to Natural Causes-Anticipated and twelve due to Natural Causes-Not Anticipated, three Accidental and one Undetermined death. The single Undetermined death was categorized as such due to an inconclusive autopsy report. The three accidental deaths were all from one CSP and categorized as such due to an autopsy not being shared with CSP, one including vehicle accident and the other resulted in choking. There were no Homicides or Suicides reported in 2014.

## 2014 Cause of Death



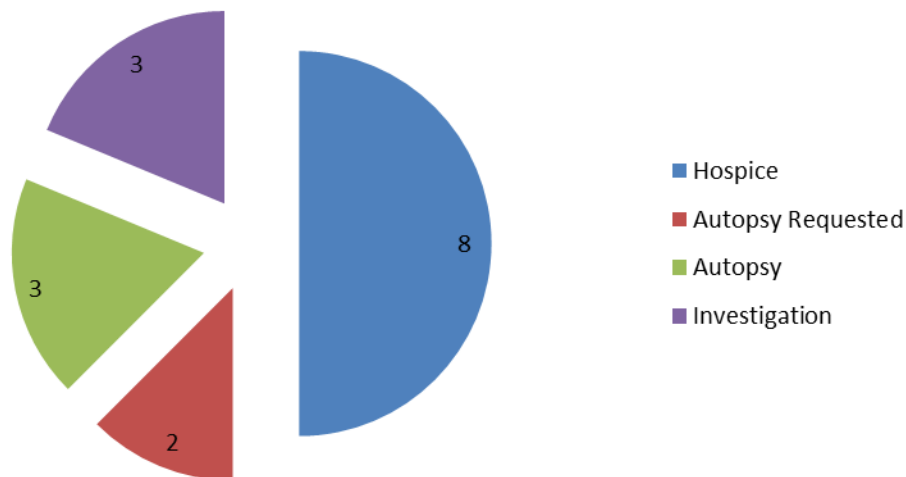
The leading causes of death in 2014 were Other (14), followed by Respiratory Disorder (10) and Neurological (4). Other category indicates that the cause of death did not fall into an available option within cause of death. There were no deaths resulting from Cardiovascular or Medication Errors.

## 2014 Place of Death



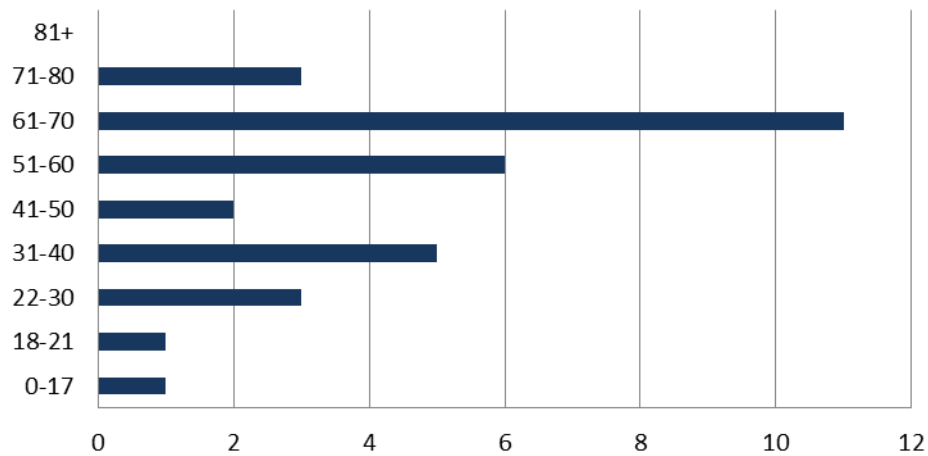
As the graph above demonstrates, 16 of the 32 incidents of death occurred in a Hospital, while 10 occurred at a Group Home, two occurred in Other and Community locations, and the remainder occurred either in the Family/Guardian Home, Other Home, Supervised Apartment and CSP/Private ICF. Of the two deaths that were reported in an Other location, one occurred in a behavioral health agency and the other incident occurred in a nursing home.

## 2014 Hospice, Autopsy, and Investigation



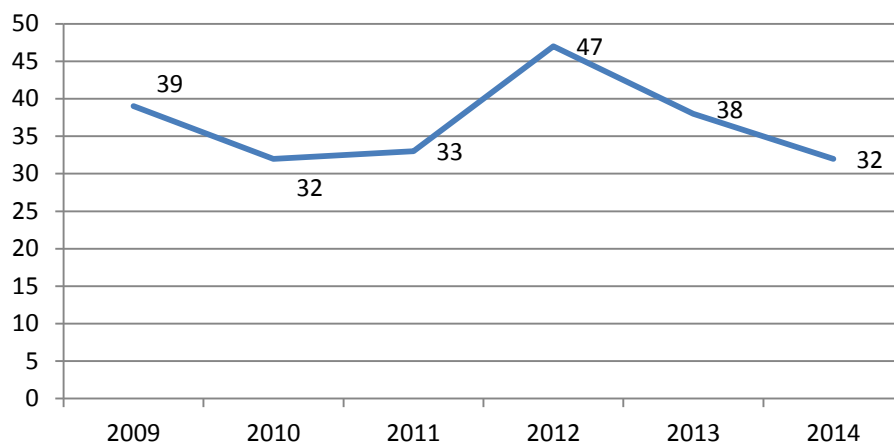
Of the 32 deaths that occurred in 2014, 16 of these were anticipated and Hospice care was provided for eight of the people. Investigations were conducted for three separate death reports, One investigation was completed by DDD, the other by Law Enforcement and one by the Coroner.

## 2014 Age Range



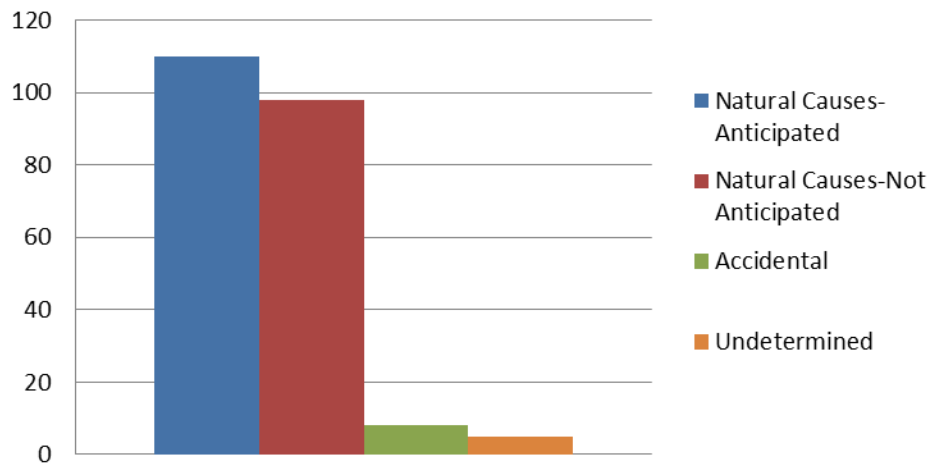
The graph above reflects the number of deaths in each age category. Eleven participants in the 61-70 year old age range died in 2014, six in 51-60, five in 31-40 and three or less in each of the age categories of 0-17, 18-21, 22-30, 41-50 and 71-80.

## 2009-2014 Total Number of Deaths



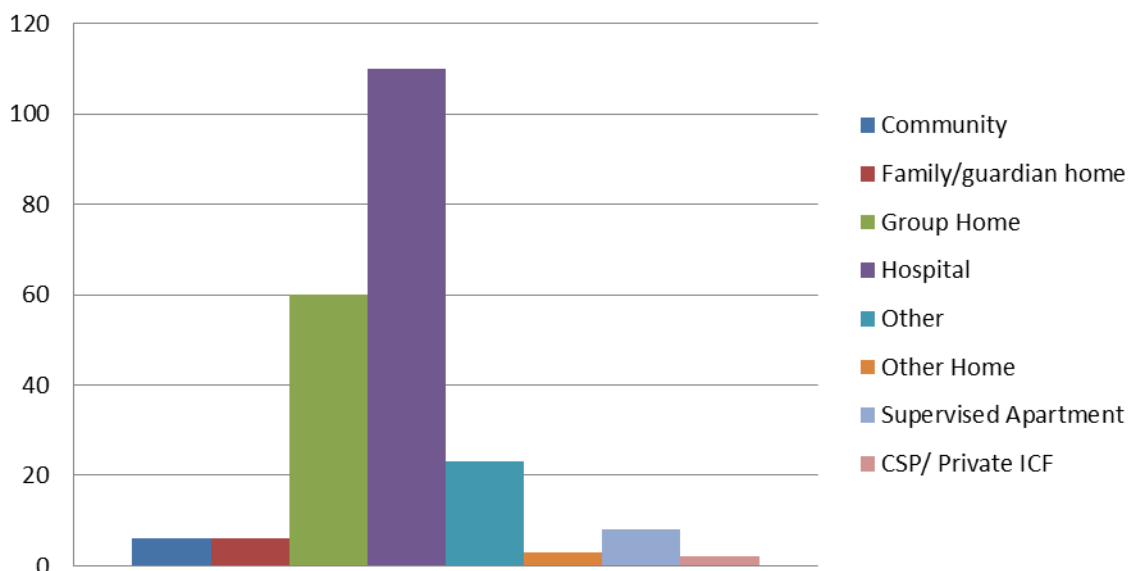
Over the course of the past six years, mortality rates have remained fairly stable. In 2012, the number of deaths increased from the previous year, and has continued to decrease each year until 2014.

## 2009-2014 Type of Death



From 2009 through 2014, the leading type of death was Natural Causes-Anticipated at 110, followed by Natural Causes-Not Anticipated at 98 deaths. Eight deaths were Accidental, five were Undetermined. During this reporting period there were no deaths reported for Suicide and Homicide.

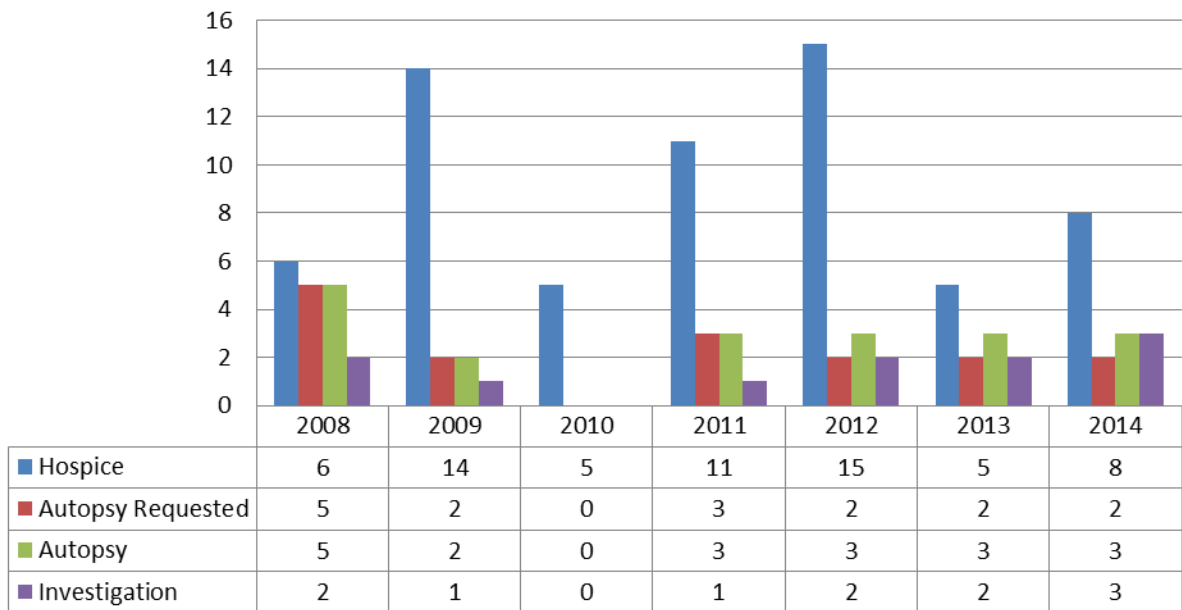
## 2009-2014 Place of Death



As the graph above demonstrates, 110 participants have passed away in Hospitals, which is just over half of the total deaths reported for 2009-2014. Sixty deaths occurred in Group Homes, and 23 occurred in “Other” locations. This information is also consistent with the 2014 data.



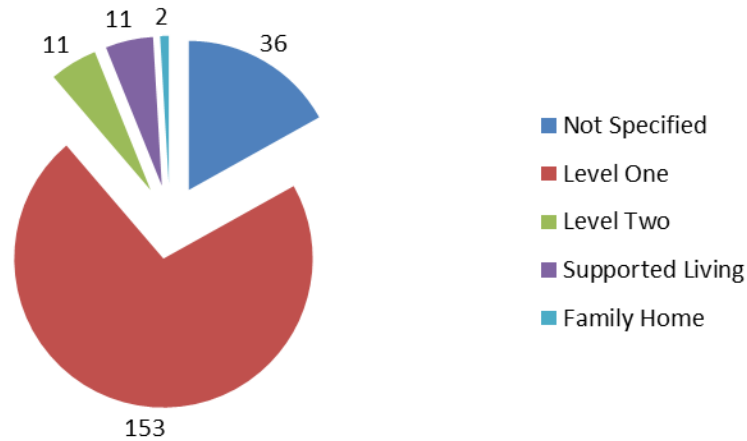
## 2009-2014 Hospice, Autopsy and Investigation



The graph above reflects actions taken prior to (Hospice services) and after (Autopsy and Investigation) the death of a participant occurs. In 2009 there was a significant increase in the use of Hospice, whereas the number of autopsies requested and performed remained relatively low. Providers should be commended for assisting participants in accessing hospice services which allow them to remain in their own home.

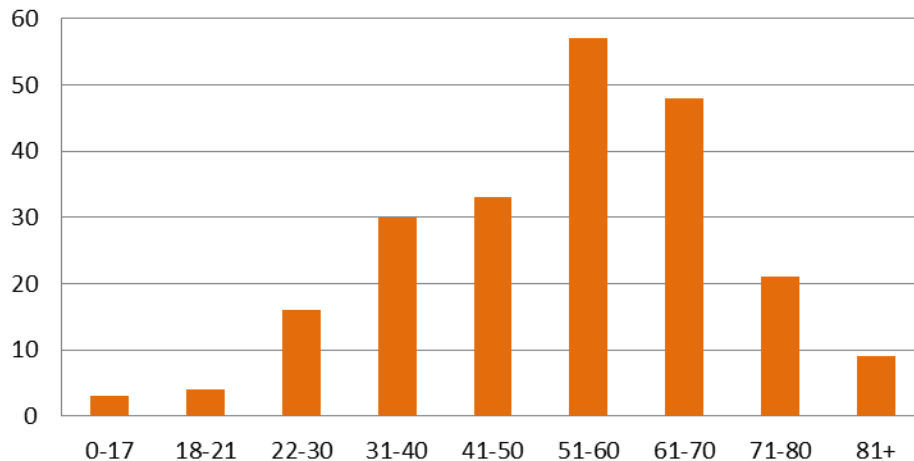
The rate of death investigations has remained relatively steady, ranging between zero to three investigations per year. Investigations may be initiated and completed by a number of agencies including the provider, law enforcement, Medicaid Fraud Control Unit, Division of Developmental Disabilities, and/or the Department of Social Services. Three investigations in 2014 were conducted by DDD, Law Enforcement, and the Coroner.

## 2009-2014 Level of Supervision



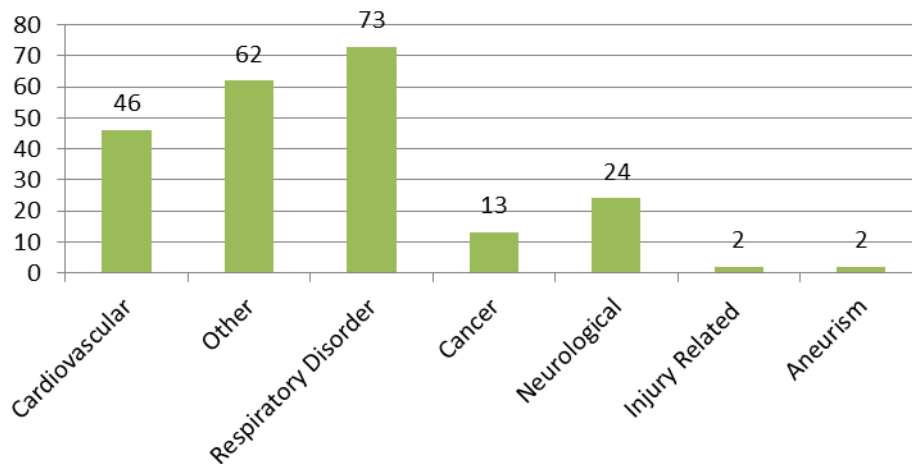
The graph and table above indicate that from 2009-2014, 153 of those who passed away were receiving Group Home (Level One) residential supports at the time of their death, followed by Not Specified, Supervised Living (Level Two) and Supported Living. Again, if the level of supervision is Not Specified, this is an indication that the participant did not receive residential supports from the provider.

## 2009-2014 Age Range



Of the 221 deaths that occurred from 2009 through 2014, 33 of those participants were in the 51-60 age range, followed by 57 deaths in the 61-70 age range, then 30 deaths in the 41-50 age range. This may be due to the increase in aging population in community-based services. The age ranges with the lowest number of mortalities are 0-17, 18-21 and over 81, likely due to the participant population being low system-wide in those age ranges. In 2014, the age range with the highest number of mortalities was 51-60, which is consistent with the overall data gathered from 2009-2014.

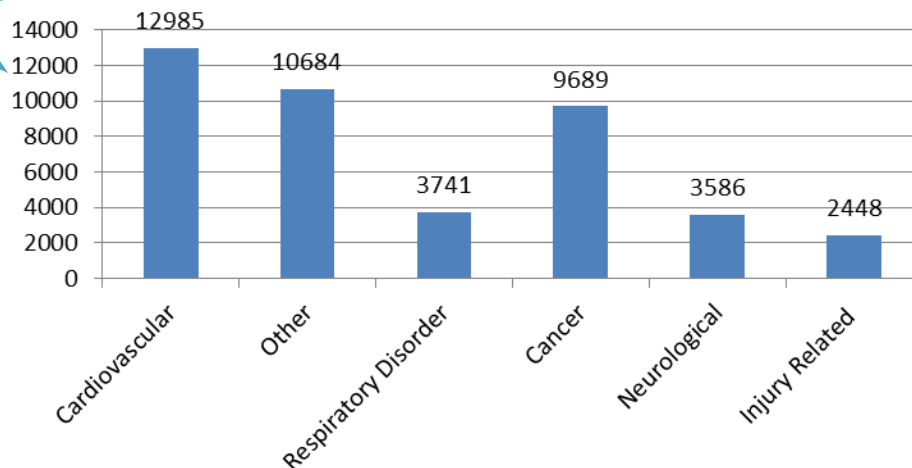
## 2009-2014 Causes of Death



The leading cause of death from 2009-2014 is Respiratory Disorder, followed by Other and Cardiovascular. The below graph contains information about the statewide causes of death for South Dakota for the same timeframe. Aneurism is not captured within statewide data as a specific category.



## 2009-2014 Statewide Causes of Death



As a new element to the CIR annual report, the causes of death for the population supported as captured in CIRs is compared with the causes of death of all people throughout the state. The leading cause of death from 2009-2014 is Cardiovascular, followed by Other and Cancer. The proportion of Cardiovascular and Cancer occur less frequently within the population supported than statewide data. Respiratory Disorder, however, is reflected at a higher occurrence rate for participants supported than statewide.

Bellow appears a chart of percentages of each cause of death with data for both the population supported and statewide.

<b>2009-2014 Percentages of Causes of Death</b>		
	<b>CSP %</b>	<b>Statewide %</b>
<b>Cardiovascular</b>	20.4%	30.1%
<b>Other</b>	27.4%	24.8%
<b>Respiratory Disorder</b>	32.3%	8.7%
<b>Cancer</b>	5.8%	22.5%
<b>Neurological</b>	10.6%	8.3%
<b>Injury Related</b>	0.9%	5.7%
<b>Aneurism</b>	0.9%	

## **SYSTEMS IMPROVEMENTS IN 2015**

The CIR process is an important and continuous aspect of DDDs' quality management system. Thorough review of the data and substantive dialogue with a variety of stakeholders resulted in a number of planned systems improvements. One of the primary functions of this annual report is to provide interested parties with a summary of planned systems improvements. They are as follows:

1. CIR/QA team will survey how the annual report information is utilized by providers and what data analysis would be most beneficial in the future;
2. CIR/QA team will provide information to the Core Stakeholders group regarding current incident review practices and findings of the 2014 CIR Report. Input will be sought from the group regarding any recommendations for incident system improvement;
3. The DDD CHOICES Waiver Manager will share CIR data on a quarterly basis with the Internal Waiver Review Committee (IWRC), who will review and provide recommendations to the CIR/QA team and DDD Director;
4. CIR/QA team will continue to provide formal and informal training annually to providers and DDD staff to promote consistency and sound data collection. These training opportunities will be tracked by the CIR team;
5. Program Specialists will conduct technical assistance with providers as needed or requested regarding clarification for CIR Guidelines and reporting expectations;
6. CIR/QA team will be assisting to revise the chemical intervention definition, process and reporting criteria to better protect the rights of individuals who receive psychotropic medications regardless of diagnosis;
7. DDD is researching the implementation of a new information system that would incorporate CIR reporting to allow for more comprehensive data collection and analysis; and

8. CIR/QA team will be partnering with the Live.Life.Well. initiative to compare data related to health conditions and compare mortality data.

The goal of these system improvements is to increase the overall quality of services and supports for people with disabilities in South Dakota.

Please direct any comments and questions about this report to Ashley Schlichenmayer-Okroi, Program Specialist, at [Ashley.Schlichenmayerokroi@state.sd.us](mailto:Ashley.Schlichenmayerokroi@state.sd.us). Phone contact can be made with Ashley at 605-773-3438.